FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044172

Facility Name: MAPLE CREST CARE CENTRE

Address: 4452 SQUAW PRAIRIE ROAD (Number) BELVIDERE (City) 61008 (Zip Code)

County: BOONE

Telephone Number: (815) 547-6377 **Fax #** (815) 547-3857

IDPA ID Number: 36-4253834

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHAEL BELLOWS

(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	86	Skilled (SNF)	86	31,390	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,514	2,338	4,805	9,657	8
9	SNF/PED					9
10	ICF	9,220	8,571	2,035	19,826	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,734	10,909	6,840	29,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.92%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 86 and days of care provided 3,569

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	167,308	9,661	7,685	184,654		184,654	(1,553)	183,101			1
2	Food Purchase		116,604		116,604		116,604	(1,510)	115,094			2
3	Housekeeping	48,850	19,092		67,942		67,942	495	68,437			3
4	Laundry	44,670	10,713	2,748	58,131		58,131	339	58,470			4
5	Heat and Other Utilities			104,845	104,845		104,845		104,845			5
6	Maintenance	57,185	17,374	28,051	102,610		102,610	(25)	102,585			6
7	Other (specify):*			3,903	3,903		3,903		3,903			7
8	**TOTAL General Services**	318,013	173,444	147,232	638,689		638,689	(2,254)	636,435			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,370,129	71,044	56,954	1,498,127		1,498,127	(22,149)	1,475,978			10
10a	Therapy	66,233		150	66,383		66,383		66,383			10a
11	Activities	83,846	5,815	3,505	93,166		93,166	(1,710)	91,456			11
12	Social Services			4,404	4,404		4,404		4,404			12
13	CNA Training											13
14	Program Transportation			50	50		50		50			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,520,208	76,859	69,863	1,666,930		1,666,930	(23,859)	1,643,071			16
	C. General Administration											
17	Administrative	85,105		366,065	451,170		451,170	(369,065)	82,105			17
18	Directors Fees											18
19	Professional Services			196,938	196,938		196,938	(155,570)	41,368			19
20	Dues, Fees, Subscriptions & Promotions			60,124	60,124		60,124	(47,826)	12,298			20
21	Clerical & General Office Expenses	67,402	28,357	23,183	118,942		118,942	95,531	214,473			21
22	Employee Benefits & Payroll Taxes			349,792	349,792		349,792		349,792			22
23	Inservice Training & Education			4,725	4,725		4,725		4,725			23
24	Travel and Seminar							5,212	5,212			24
25	Other Admin. Staff Transportation			3,431	3,431		3,431		3,431			25
26	Insurance-Prop.Liab.Malpractice			145,031	145,031		145,031	2,829	147,860			26
27	Other (specify):*			24,478	24,478		24,478	(24,478)				27
28	**TOTAL General Administration**	152,507	28,357	1,173,767	1,354,631		1,354,631	(493,367)	861,264			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,990,728	278,660	1,390,862	3,660,250		3,660,250	(519,480)	3,140,770			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: MAPLE CREST CARE CENTRE #0044172 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,960	
	REPAIRS & MAINTENANCE		725	
			0	7,685
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,748	
			0	2,748
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		58,830	
	ELECTRICITY		38,476	
	WATER		7,539	
	CABLE TV - LOBBY		0	
			0	104,845
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,452	
	PAINTING & DECORATING		484	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		14,391	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,916	
	FIRE SERVICE		2,808	
			0	
			0	
			0	28,051
7	**OTHER**			
	SCAVENGER		3,690	
	SECURITY SERVICE		213	3,903
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,800	4,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	836	
	PHARMACY CONSULTANT	XVIII B 39-2	936	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	55,182	
			0	
			0	56,954
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		22	
	SPEECH THERAPY SERVICES		128	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	150
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		1,670	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,835	
			0	3,505
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,404	
			0	4,404
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MAPLE CREST CARE CENTRE #0044172 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		50	50
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	366,065	366,065
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	27,734	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	169,204	
			0	196,938
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	25,151	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	18,619	
	EMPLOYEE WANT ADS	XIX F	2,641	
	CONTRIBUTIONS	VI 20 XIX F	25	
	DUES & SUBSCRIPTIONS	XIX F	5,948	
	LICENSES & PERMITS	XIX F	2,335	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,269	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,524	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	612	60,124
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,054	
	EQUIPMENT REPAIR & MAINTENANCE		1,193	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	186	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		3,025	
	TELEPHONE		15,399	
	MESSENGER SERVICE		1,326	
			0	23,183

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	142,527	
	UNEMPLOYMENT COMPENSATION	XIX D	20,738	
	WORKERS COMPENSATION INSURANCI	XIX D	38,301	
	HOSPITALIZATION INSURANCE	XIX D	139,733	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,024	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,110	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	3,359	
	CHICAGO HEAD TAX	XIX D	0	349,792
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,725	4,725
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,431	3,431
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		145,031	145,031
27	**OTHER**			
	BAD DEBTS	VI 24	24,478	
				24,478

GRAND TOTAL COLUMN 3 OTHER 1,390,862

MAPLE CREST CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	116,604	PATIENT MEALS	88449
LESS SALES TAX	(1,510)	ADD EMPLOYEE MEALS	0
NET FOOD	115,094	TOTAL MEALS/YEAR	88449
TOTAL PATIENT CENSUS	29,483	NET FOOD	115094
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	88449
TOTAL PATIENT MEALS	88449	COST PER MEAL	1.3
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number MAPLE CREST CARE CENTRE #0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			50,160	50,160		50,160	(3,616)	46,544			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,095	82,095		82,095	(9,287)	72,808			32
33	Real Estate Taxes			31,916	31,916		31,916		31,916			33
34	Rent-Facility & Grounds			80,860	80,860		80,860	19,092	99,952			34
35	Rent-Equipment & Vehicles			11,671	11,671		11,671	4,807	16,478			35
36	Other (specify):* STORAGE											36
37	**TOTAL Ownership**			256,702	256,702		256,702	10,996	267,698			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		110,832	164,885	275,717		275,717		275,717			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		110,832	211,970	322,802		322,802		322,802			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,990,728	389,492	1,859,534	4,239,754		4,239,754	(508,484)	3,731,270			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,616)	30		9
10	Interest and Other Investment Income	(9,287)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,510)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(186)	21		18
19	Entertainment	(25,151)	20		19
20	Contributions	(3,549)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(5,123)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,478)	27		24
25	Fund Raising, Advertising and Promotional	(18,619)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,269)	20		28
29	Other-Attach Schedule	(9,009)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,797)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(406,687)	PG 6-6C	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (406,687)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (508,484)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MAPLE CREST CARE CENTRE

ID# 0044172

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	VACATION ACCRUAL	(1,553)	1	2
3	VACATION ACCRUAL	495	3	3
4	VACATION ACCRUAL	339	4	4
5	VACATION ACCRUAL	(25)	6	5
6	VACATION ACCRUAL	(2,529)	10	6
7	VACATION ACCRUAL	(1,710)	11	7
8	VACATION ACCRUAL	(3,754)	17	8
9	VACATION ACCRUAL	(272)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,009)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,553)	0	0	0	0	0	0	0	0	0	0	(1,553)	1
2	Food Purchase	(1,510)	0	0	0	0	0	0	0	0	0	0	(1,510)	2
3	Housekeeping	495	0	0	0	0	0	0	0	0	0	0	495	3
4	Laundry	339	0	0	0	0	0	0	0	0	0	0	339	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(25)	0	0	0	0	0	0	0	0	0	0	(25)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,254)	0	0	0	0	0	0	0	0	0	0	(2,254)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,529)	0	(19,620)	0	0	0	0	0	0	0	0	(22,149)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,710)	0	0	0	0	0	0	0	0	0	0	(1,710)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,239)	0	(19,620)	0	0	0	0	0	0	0	0	(23,859)	16
	C. General Administration													
17	Administrative	(3,754)	(273,795)	0	0	(91,516)	0	0	0	0	0	0	(369,065)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,123)	(33,579)	710	(117,578)	0	0	0	0	0	0	0	(155,570)	19
20	Fees, Subscriptions & Promotions	(48,588)	423	142	197	0	0	0	0	0	0	0	(47,826)	20
21	Clerical & General Office Expenses	(458)	14,832	1,053	80,104	0	0	0	0	0	0	0	95,531	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,471	2,449	1,292	0	0	0	0	0	0	0	5,212	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	835	997	997	0	0	0	0	0	0	0	2,829	26
27	Other (specify):*	(24,478)	0	0	0	0	0	0	0	0	0	0	(24,478)	27
28	**TOTAL General Administration**	(82,401)	(289,813)	5,351	(34,988)	(91,516)	0	0	0	0	0	0	(493,367)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(88,894)	(289,813)	(14,269)	(34,988)	(91,516)	0	0	0	0	0	0	(519,480)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,616)	0	0	0	0	0	0	0	0	0	0	(3,616)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,287)	0	0	0	0	0	0	0	0	0	0	(9,287)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	592	18,500	0	0	0	0	0	0	0	19,092	34
35	Rent-Equipment & Vehicles	0	1,528	2,170	1,109	0	0	0	0	0	0	0	4,807	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,903)	1,528	2,762	19,609	0	0	0	0	0	0	0	10,996	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(101,797)	(288,285)	(11,507)	(15,379)	(91,516)	0	0	0	0	0	0	(508,484)	45

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		SEE ATTACHED LIST OF RELATED BUSINESS ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	ADMINISTRATIVE	$ 274,549	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		$ 754	$ (273,795)	1
2	V	19	PROFESSIONAL FEES	40,251	" "		6,672	(33,579)	2
3	V	20	DUES & SUBSCRIPTIONS		" "		423	423	3
4	V	21	CLERICAL		" "		14,832	14,832	4
5	V	24	TRAVEL		" "		1,471	1,471	5
6	V	26	INSURANCE		" "		835	835	6
7	V	35	RENT - EQPT & VEHICLES		" "		1,528	1,528	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 314,800			$ 26,515	$ * (288,285)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 55,182	CARLYLE NURSING ASSOCIATES, LLC		$ 35,562	$ (19,620)	15
16	V	19	PROFESSIONAL FEES		" "		710	710	16
17	V	20	DUES & SUBSCRIPTIONS		" "		142	142	17
18	V	21	CLERICAL		" "		1,053	1,053	18
19	V	24	TRAVEL		" "		2,449	2,449	19
20	V	26	INSURANCE		" "		997	997	20
21	V	30	DEPRECIATION		" "				21
22	V	34	RENT		" "		592	592	22
23	V	35	RENT - EQPT & VEH.		" "		2,170	2,170	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 55,182			$ 43,675	$ * (11,507)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 119,956	THE KENSINGTON GOUP, LLC		$ 2,378	$ (117,578)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		197	197	16
17	V	21	CLERICAL		" "		80,104	80,104	17
18	V	24	TRAVEL		" "		1,292	1,292	18
19	V	26	INSURANCE		" "		997	997	19
20	V	30	DEPRECIATION		" "				20
21	V	34	RENT		" "		18,500	18,500	21
22	V	35	RENT - EQPT & VEH.		" "		1,109	1,109	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 119,956			$ 104,577	$ * (15,379)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 91,516	CHESTERFIELD, LLC		$	$ (91,516)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 91,516			$ 0	$ * (91,516)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WITTINGHAM MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	328,617	6	$ 74,383	$	29,483	$ 6,672	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	328,617	6	4,713		29,483	423	2
3	21	CLERICAL	PATIENT DAYS	328,617	6	165,350	139,276	29,483	14,832	3
4	24	TRAVEL	PATIENT DAYS	328,617	6	16,404		29,483	1,471	4
5	26	INSURANCE	PATIENT DAYS	328,617	6	9,305		29,483	835	5
6	35	RENT - EQPT & VEH.	PATIENT DAYS	328,617	6	17,037		29,483	1,528	6
7	17	ADMINISTRATIVE	PATIENT DAYS	328,617	6	8,406	8,406	29,483	754	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 295,598	$ 147,682		$ 26,515	25

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	9	$ 35,562	$ 35,562	1	$ 35,562	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	11,646		29,483	710	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	2,323		29,483	142	3
4	21	CLERICAL	PATIENT DAYS	483,650	9	17,276		29,483	1,053	4
5	24	TRAVEL	PATIENT DAYS	483,650	9	40,167		29,483	2,449	5
6	26	INSURANCE	PATIENT DAYS	483,650	9	16,351		29,483	997	6
7	30	DEPRECIATION	PATIENT DAYS	483,650	9			29,483		7
8	34	RENT	PATIENT DAYS	483,650	9	9,715		29,483	592	8
9	35	RENT - EQPT & VEH.	PATIENT DAYS	483,650	9	35,603		29,483	2,170	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 168,643	$ 35,562		$ 43,675	25

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	$ 39,055	$	29,483	$ 2,378	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	3,234		29,483	197	2
3	21	CLERICAL	PATIENT DAYS	483,650	9	1,315,340	1,150,879	29,483	80,104	3
4	24	TRAVEL	PATIENT DAYS	483,650	9	21,213		29,483	1,292	4
5	26	INSURANCE	PATIENT DAYS	483,650	9	16,374		29,483	997	5
6	30	DEPRECIATION	PATIENT DAYS	483,650	9			29,483		6
7	34	RENT	PATIENT DAYS	483,650	9	303,769		29,483	18,500	7
8	35	RENT - EQPT & VEH.	PATIENT DAYS	483,650	9	18,215		29,483	1,109	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,717,200	$ 1,150,879		$ 104,577	25

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MEMBER LOANS	X		WORKING CAPITAL	DEMAND	VARIES	150,000	251,421	DEMAND	0.0775	18,084	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	721,000	496,444	DEMAND	VARIES	63,061	7
8	LETTER OF CREDIT FEE		X								950	8
9	TOTAL Facility Related						$ 871,000	$ 747,865			$ 82,095	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 871,000	$ 747,865			$ 82,095	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	30,192	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	30,884	2
3. Under or (over) accrual (line 2 minus line 1).	$	692	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,224	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	31,916	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	48,238	8
2001	46,974	9
2002	30,960	10
2003	29,862	11
2004	30,884	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAPLE CREST CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044172

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-14-100-015	NURSING HOME	$ 30,883.72	$ 30,883.72
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,883.72	$ 30,883.72

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	653,400		$	1
2					2
3	TOTALS	653,400		$	3

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL COVERING/BORDERS/VINYL COVERINGS			1999	17,944	2,563	7	2,563		17,183	9
10	STEEL DOORS			1999	2,337	85	27.5	85		565	10
11	SIGN, SIGN FOOTINGS AND BRICKS			1999	4,652	169	27.5	169		1,035	11
12	REMODEL - DINING & REC. ROOM, OFFICES, HALLS			1999	73,951	2,690	27.5	2,690		16,700	12
13	CONDENSING UNIT FOR WALK IN FREEZER			2000	3,695	134	27.5	134		687	13
14	WATER SOFTENER UNIT			2000	10,120	368	27.5	368		1,886	14
15	ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS			2001	11,239	409	27.5	409		2,028	15
16	TWO HOT WATER HEATERS			2001	13,065	475	27.5	475		2,355	16
17	REMOVAL OF WATER TANKS & PIPING			2001	7,650	278	27.5	278		1,355	17
18	REPAIRS TO GRAVEL ROOF			2001	2,875	105	27.5	105		485	18
19	BLACTOP PARKING LOT			2001	1,270	46	27.5	46		213	19
20	AIRCONDITIONING - REPAIRS & INSTALLATION - DINING RM.			2001	7,430	270	27.5	270		1,226	20
21	ASBESTOS ABATEMENT/FLOOR RENOVATION			2001	1,400	51	27.5	51		230	21
22	REPLACE WATER COIL - FOOD STORAGE AREA			2001	7,500	273	27.5	273		1,194	22
23	INSTALL CONTROL DAMPER IN BATHING AREA			2001	1,795	65	27.5	65		274	23
24	BOILER ROOM EXHAUST FAN			2001	1,980	72	27.5	72		303	24
25	REPLACE DAMPER ON GENERATOR			2001	1,260	46	27.5	46		190	25
26	ADDITION OF 6 BEDS - GENERAL CONST/WINDOWS/PAINTING			2001	103,815	3,775	27.5	3,775		15,572	26
27	EXHAUST FANS FOR KITCHEN & DISHWASHING AREA			2001	5,894	214	27.5	214		883	27
28	AIR CONDITIONING CONDENSING UNIT			2002	8,557	311	27.5	311		1,140	28
29	ROOF REPAIR OVER LAUNDRY RM, RMS 212 & 114 FOYER			2002	9,800	356	27.5	356		1,246	29
30	ROOF REPAIRS			2002	2,030	74	27.5	74		234	30
31	ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS			2003	5,607	204	27.5	204		510	31
32	CONSTRUCTION OF 2 BED ADDITION - FROM 84 BEDS TO 86			2003	76,097	2,767	27.5	2,767		6,918	32
33	ROOF REPAIRS - IN THE VALLEY, LAUDRY RM & BEAUTY SALO			2003	4,627	168	27.5	168		420	33
34	NEW A/C UNIT IN DINING ROOM			2003	16,997	618	27.5	618		1,545	34
35	25 TON BRYANT CONDENSING UNIT - OFFICE AREA			2004	10,620	386	27.5	386		612	35
36	ELECTRICAL REPAIRS ON CONDUITS IN KITCHEN FLOOI			2004	4,407	160	27.5	160		227	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REMOVE OLD TILE AND INSTALL NEW ONES IN KITCHEN	2004	$ 1,400	$ 51	27.5	$ 51	$	$ 72	37
38	REPLACE EXISTING SEWER LINE/REPLACE SINK FAUCET/								38
39	REPAIR DRAIN LINE & PIPE CONCRETE WALL - KITCHEN	2004	10,000	364	27.5	364		516	39
40	KITCHEN TILES - BEHIND DISHWASHER AND SINKS	2005	1,500	55	27.5	55		55	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 431,514	$ 17,602		$ 17,602	$	$ 77,859	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 248,477	$ 26,270	$ 26,714	$ 444	3-15 YRS	$ 113,324	71
72	Current Year Purchases	44,569	6,288	2,228	(4,060)	10 YRS	2,228	72
73	Fully Depreciated Assets	21,721						73
74	RELATED PARTY							74
75	TOTALS	$ 314,767	$ 32,558	$ 28,942	$ (3,616)		$ 115,552	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 746,281	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 50,160	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 46,544	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,616)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 193,411	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: COUNTY OF BOONE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		78	02/01/99	$ 80,860			3
4	Additions	12/11/2001	6					4
5		5/13/2003	2					5
6								6
7	TOTAL		86		$ 80,860 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning 02/01/99
Ending 02/01/30

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 84,095
13.	12/31/2007	$ 94,769
14.	12/31/2008	$ 98,561

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 9,381 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2003 HONDA CIVIC	$ 229.00	$ 2,290	17
18					18
19					19
20					20
21	TOTAL		$ 229.00	$ 2,290	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number MAPLE CREST CARE CENTRE

STATE OF ILLINOIS
0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 72,078	$		$ 72,078	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,602			15,602	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			77,205			77,205	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				98,675		98,675	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, I.V. THERAPY & Other (specify): RENTALS	39-2					12,157		12,157	13
14	TOTAL			$		$ 164,885	$ 110,832		$ 275,717	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE **#** 0044172 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 134,846	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 51,039)	654,401		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,895		6
7	Other Prepaid Expenses	59,181		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 885,323	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	222,818		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	431,514		15
16	Equipment, at Historical Cost	314,766		16
17	Accumulated Depreciation (book methods)	(326,413)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 642,685	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,528,008	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 176,797	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,583		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,303		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,542		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,224		32
33	Accrued Interest Payable	1,399		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	19,648		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 413,496	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	747,865		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 747,865	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,161,361	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 366,647	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,528,008	$	48

***(See instructions.)**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 111,677	1
2	Restatements (describe):		2
3	**ROUNDING ADJ.**	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 111,675	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	354,972	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 254,972	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 366,647	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,585,439	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,585,439	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,287	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,287	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,594,726	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	638,689	31
32	Health Care	1,666,930	32
33	General Administration	1,354,631	33
	B. Capital Expense		
34	Ownership	256,702	34
	C. Ancillary Expense		
35	Special Cost Centers	275,717	35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,239,754	40
41	**Income before Income Taxes (line 30 minus line 40)****	354,972	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 354,972	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,065	2,147	$ 84,670	$ 39.44	1
2	Assistant Director of Nursing	1,964	2,086	56,255	26.97	2
3	Registered Nurses	13,939	14,927	382,669	25.64	3
4	Licensed Practical Nurses	8,263	9,002	188,097	20.90	4
5	CNAs & Orderlies	47,898	51,723	571,215	11.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,571	3,972	66,233	16.67	8
9	Activity Director	2,028	2,086	30,954	14.84	9
10	Activity Assistants	5,839	6,127	52,892	8.63	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,957	8,531	105,356	12.35	14
15	Cook Helpers/Assistants	7,530	8,001	61,952	7.74	15
16	Dishwashers					16
17	Maintenance Workers	3,765	3,927	57,185	14.56	17
18	Housekeepers	6,720	7,237	48,850	6.75	18
19	Laundry	5,649	6,043	44,670	7.39	19
20	Administrator	1,984	2,086	85,105	40.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,272	3,703	67,402	18.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,834	4,150	87,223	21.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,278	135,748	$ 1,990,728 *	$ 14.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 6,960	1-3	35
36	Medical Director	24	4,800	9-3	36
37	Medical Records Consultant	16	836	10-3	37
38	Nurse Consultant		55,182	10-3	38
39	Pharmacist Consultant	96	936	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	29	1,835	11-3	44
45	Social Service Consultant	72	4,404	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	393	$ 74,953		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARIE HARTZOG	ADMIN		$ 85,105
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,105

B. Administrative - Other

Description	Amount
WITTINGHAM MANAGEMENT ASSOC. LLC MNGMT FEE	$ 274,549
CHESTERFIELD LLC MANAGEMENT FEE	91,516
TOTAL (agree to Schedule V, line 17, col. 3)	$ 366,065
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		196,938
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 196,938

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,301
Unemployment Compensation Insurance	20,738
FICA Taxes	142,527
Employee Health Insurance	139,733
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,024
EMPLOYEE PHYSICAL EXAMS	1,110
PENSION/PROFIT SHARING PLANS	3,359
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 349,792

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,641
Health Care Worker Background Check	612
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	45,039
TRUST/FRANCHISE/CONTRIB/ETC	3,549
LICENSES & PERMITS	2,335
DUES & SUBSCRIPTIONS	5,948
MGMT CO ALLOCATION	762
TRUST/FRANCHISE/CONTRIB/ETC	(3,549)
Less: Public Relations Expense	(25,151)
Non-allowable advertising	(18,619)
Yellow page advertising	(1,269)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,298

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	5,212
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,212

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$ 0		$	$	$	$ 0	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. COUNCIL ON LTC. - $4536**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **675** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **47,085**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees